

EXHIBIT 3

EXPRESSION OF INTERMEDIARY PREFERENCES

Name of Facility
Street Address
City, State, ZIP Code

Dear _____:

RE: (Name and Address of Facility Here)

In order to assure that the Centers for Medicare & Medicaid Services has your intermediary preference on record, would you please identify the organization you have selected as intermediary for your facility.

Please write your selection in the space provided at the bottom of this page. Be sure to sign this form and return it as soon as possible.

Sincerely yours,

State Agency

(Intermediary Choice)

(Signature)